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Maine HICKRC

Health Information Connectivity-Knowledge Rural Consortium (HICKRC)

Network Narrative

April 2014 (Revised June 2014)

Introduction

The purpose of the HICKRC consortium is to ensure high quality, affordable digital connectivity that includes tele-health, exchange of electronic health records; collection of data through Health Information Exchanges and other entities; exchange of large image files and the use of real-time and delayed video conferencing for a wide range of telemedicine, consultation, training, and other health care purposes that will provide residents of Maine with the best health care possible. HICKRC's vision is to have all Maine single physician practices, small primary care practices, nursing homes, rural health centers, clinics and large physician practices plus hospitals connected to a secure resilient broadband network.

The Health Information Connectivity-Knowledge Rural Consortium consists of **59** rural health clinics, community health centers, and community mental health centers that serve patients in eleven out of sixteen Maine counties. (Represented by table below)

16 Maine Counties	11 Counties with HCF Participants	5 Non-HCF Counties
Androscoggin	107,604	0
Aroostook	70,055	0
Cumberland	285,456	0
Franklin	30,495	0
Hancock	0	54,845
Kennebec	121,164	0
Knox	0	39,550
Lincoln	0	34,088
Oxford	57,277	0
Penobscot	153,364	0
Piscataquis	0	17,124
Sagadahoc	0	35,013
Somerset	51,706	0
Waldo	38,940	0
Washington	32,190	0
York	199,431	0
Total	1,147,682	180,620
2013 US Census Bureau		

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http://quickfacts.census.gov/qfd/states/23/23031.html

Additional health agencies may be gained at a later date including local health departments/agencies and post-secondary institutions/teaching hospitals/medical schools. Another purpose of the HICKRC is to connect rural Health Care Providers (HCPs) with urban HCPs to provide the best care possible to all Maine patients no matter where geographically the patient presents for care. Building-out existing, dedicated broadband fiber network services and using existing broadband infrastructure in Maine is the main strategy for the HICKRC Network Design. While many urban and rural businesses have access to highspeed broadband up to Tier 7 many HCPs in Maine are rural and do have access to highspeed broadband. The HICKRC funding opportunity will greatly enhance the ability of these HCPs.

A. Maine Health Information Connectivity Knowledge Rural Consortium Goals and Objectives

Access and Quality:

- a. Increase the current percentage of quality bandwidth service access points for healthcare telecommunication, tele-health and telemedicine in the State of Maine;
- b. Provide increased, up to Tier 7 bandwidth for applications of their choosing;
- c. Introduce and increase access and user choice in rural areas;
- d. Facilitate reporting of clinical quality data to various local, State and federal government agencies and payers through access and quality broadband service;
- e. Assist regional health care providers increase access to information systems such as Health Information Exchanges (and other entities); and
- f. Seamless transition of patient care.

Equity and Security:

- a. Provide rapid access to, and transmission of, patient data and information from multiple sources and providers;
- b. Incorporate digital connections for rural residents to specialty services; and
- c. Facilitate reporting of clinical quality data to various local, State and federal government agencies and payers.

Efficiency:

- a. Leverage current, Maine broadband assets and service infrastructures, to extend and connect broadband services to rural and urban health care providers throughout Maine; and
- b. Increase bandwidth (up to Tier 7) especially in rural areas to decrease travel to specialty services in urban areas and enable or increase availability of distant learning/training to healthcare providers in all areas of Maine.

B. Strategy for aggregating the specific needs of health care providers

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HICKRC urban and rural health care providers in Maine have come together under the umbrella of a Consortium led by participants (Members), State agencies, and the MaineCare Meaningful Use Program, within the Office of MaineCare Services, in the Maine Department of Health and Human Services. The Consortium will leverage available funding under the Healthcare Connect Fund, and serve as a focal point of obtaining capability and access to high speed broadband services. The HICKRC will meet the broadband needs of the HCPs through economies of scale which allow rural and smaller HCPs the ability to “bulk purchase” broadband and at higher tiers of service for rates that are unavailable to them at this time due to market forces. Aggregating the “demand” for services for 59 HCP sites creates a business case for internet service providers that may not have taken a “business risk” to provide services for individual rural HCPs. It also creates stability for both the HCP and the internet service provider by establishing a longer-term contract with fixed prices and known revenues.

The size of the HICKRC consortium allows individual participants to collaborate with other participants and collectively negotiate contracts with internet service providers at all of their sites thus creating efficiencies and improved quality of care among the sites. The ability to send large packets of information, such as those needed by tele-health require the tiers of service that the HICKRC was formed to promote.

In a rural state such as Maine, it is not uncommon for a patient who is, say injured in a car accident, to be taken to an Emergency Room where MRIs or CAT scans are taken and read. In some cases the patient is then air transported to a larger hospital. If the tier of service required to send the MRI or CAT to the larger hospital is unavailable, another MRI or CAT scan is performed at the larger hospital. This results in additional costs, duplicate services, and delay in care. The HICKRC assists these smaller HCPs to obtain access to high-speed broadband which not only helps the provider but improves quality of care for the patient.

The proposed bandwidth capacity will expand the flexibility to implement future broadband services and programs to support Health Information Exchange (HIE). A key current and future use of the network is in the transmission of large clinical files and health information securely and efficiently. The broadband services sought by the HICKRC allow individual participants to enhance the security of their transmissions and more easily meet the rigors of the federal Health Insurance Portability and Access Act (HIPAA) and State privacy and confidentiality laws.

The HICKRC network narrative and broadband capacity described in Section C allows for and facilitates connectivity and use of various applications noted in Section D.

C. Strategy for leveraging existing technology for the most efficient and cost effect means of connecting HCPs.

The HICKRC will offer Members the ability to leverage existing technology and to improve their access and services through the following:

- Membership without cost (versus upfront fees to join)

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- State run consortium (versus regional)
- Continue to seek funding (whereas pilot programs and other initiatives will not seek additional HCF funding)
- HICKRC and State of Maine Health Information Technology Healthcare Initiatives intertwine
 - Includes Tele-health
 - Includes HIE
 - Includes Education
- HICKRC and State of Maine Office of Information Technology (including the Meaningful Use Program) meet weekly to address the needs of consortium members.

The Consortium will use existing technology where available. The State's ConnectME Authority conducts bi-annual surveys of broadband connectivity and access to high speed internet. In 2013, the Meaningful Use Program collaborated with the ConnectME Authority to complete a more thorough analysis of healthcare facilities (anchor institutions). The *2013 Broadband Baseline Survey* resulted in a comprehensive findings and recommendations report designed to build on the efficiencies of the current technology being used while promoting high tiers of service and connectivity. The Report found:

Healthcare Organizations

Availability - The 2013 survey results, which are based on a new expanded survey, show that 98 percent of surveyed healthcare facilities have access to the internet, an increase of 8 percentage points since 2011. 95 percent of surveyed organizations have access to broadband, an increase of 7 percentage points since 2011. In terms of specific broadband technologies, 61 percent have access to cable, 53 percent to DSL, 34 percent to fiber optic, and 32 percent to T-1. The availability of mobile wireless—whether at broadband speeds or not—is also relatively high at 30 percent

Use – Seventy nine percent of respondent health organizations exhibit heavy computer use (68% almost all of the time; 11% most of the day, almost every day). Only 1 percent indicated they had not used the computer at all in the previous week, and 2 percent indicated that they had no computer at the practice location.

The percentage of respondents that use some form of broadband is relatively high at 95 percent. In terms of specific broadband technologies, 43 percent connect to cable, 29 percent to DSL, and 22 percent to T-1. Only 4 percent use fiber optic or fixed wireless technologies. 12 percent use mobile devices to connect. As is characteristic with other consumer groups, including households, businesses, and CAIs, a gap exists between the percentage of healthcare organizations that have no internet connection and would like to connect (46%) and the percentage of those that plan to connect in the next 12 months (33%). The gap within this stakeholder group appears to be smaller, however, by at least 10 percentage points.

Similar to businesses and CAIs, healthcare organizations connect to the internet first and foremost to conduct basic communications (98%) and office functions, such as recordkeeping (74%) and managing finances and billing (67%). Other major reasons to connect are to provide or access training online (77%) and to conduct the healthcare practice (63%). Significantly lower are the percentages of respondents who use the internet to participate in the HealthInfoNet health information exchange (HIE) (22%), to provide telemedicine services (13%), and transmit medical imagery (13%).

With faster internet, the largest percentage of respondents indicated that they would do more Telemedicine/Tele-health (32%), recordkeeping (24%), and online training (23%), although over half indicated that their internet service is sufficiently fast (55%). When questioned separately on internet speed specifically, however, a sizable percentage (40%) indicated that, although the practice can do what it needs with current speeds, faster internet would be better.

The 2013 survey findings indicate that 64 percent of respondents have installed and use an EHR system, and of that 64 percent, over 80 percent use the system heavily. Healthcare organizations more likely to report that they have installed and used an EHR system are ambulatory healthcare facilities (86.5%), FQHCs or RHCs (85.7%), behavioral health facilities (72.5%), dental facilities (70.0%), and respondents that are affiliated with a hospital (86.6%) or part of an FQHC or RHC (84.0%).

Drivers - The availability of new online healthcare technologies, such as the HIE, electronic health records (EHRs), e-prescribing, and telemedicine systems, are major drivers of high-capacity broadband connectivity among Maine's healthcare organizations.

Drivers of computer and internet use - A major driver of high-capacity broadband connectivity is Maine's HIE, a secure, interoperable network for centralizing and sharing healthcare information with healthcare organizations, providers, public health agencies and consumers statewide administered through Maine's HealthInfoNet, a public-private nonprofit organization, and supported by federal grant monies under the Health Information Technology for Economic and Clinical Health Act, the network currently connects 35 out of 38 Maine hospitals and many of Maine's healthcare facilities. One-third of the 2013 survey respondents are connected; the highest percentage of participation is shown among FQHCs or RHCs (57.1%), behavioral health facilities (51.4%), ambulatory healthcare facilities (45.9%), and those facilities that are affiliated with a hospital (73.7%) or part of an FQHC or RHC (60.0%).

Although the HIE is widely subscribed to, most health care practices have read-only (82%) rather than interactive access for data exchange. 64 percent of respondents have installed and use an EHR system, and of that 64 percent, over 80 percent use the system heavily. Of those respondents

that use an EHR system less than 50 percent of the time, almost half (47%) indicated that they are still in the process of implementing such a system. In comparison with EHR systems, respondents' use of e-prescribing (27%) and telemedicine systems (7%), additional drivers of broadband adoption, is relatively low. It is important to note that the largest percentage of respondents (32%) indicated they would do more telemedicine if they had faster internet.

Barriers - Although the Maine healthcare community has made meaningful gains since 2011 in using broadband to deliver services, barriers still exist in the adoption of internet and specific health information technologies that improve patient care and drive broadband adoption. As with other consumer groups, lack of awareness of broadband benefits (including federal payment incentives), access to adequate service, and perceived value for the cost continue to be the biggest barriers. Lack of IT support in small practices also continues to be a barrier, although a significant percentage (66%) of 2013 respondents indicated that they have an employee dedicated to IT duties.

Section 4.2.5.

The full report can be found at:

<http://www.maine.gov/connectme/grants/ntia/planning.shtml>

The HICKRC will use continue to use the current technology described above, such as cable, DSL, and T-1 for those sites where higher speed broadband is not practicable nor feasible. The goal of the HICKRC is to use economies of scale and to leverage funding to enhance the current technology with fiber optics and fixed wireless where feasible. The HICKRC is offering membership without cost for consortium members; this is a defining leveraging point for its Members as other broadband initiatives offer cost-based membership which is prohibitive and dissuasive for many. Additionally, some current initiatives are not seeking additional funding which leaves Members looking for a new consortium. As documented above, the Consortium will leverage the findings of the broadband survey to use current technology while mindful that technology improves as a rapid pace. A State run consortium provides a strong leverage point. When broadband funding is decreased by 65% for Members, that money can be used to participate in HIE, tele-health and education.

D. How the broadband services will be used to improve or provide health care delivery

The Consortium will use the results of the ConnectME Authority survey and support the recommendations of how health care delivery and broadband services can be used to improve quality and costs:

- *Consider redefining minimum broadband service at a speed level 3 to 6 Mbps, formalizing the definition of underserved, as provisioned in the Advanced*

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Technology Infrastructure Act Enlarging the area of unserved and identifying areas of underserved in the state will:

- ⌘ Help focus funding on higher-capacity broadband services to meet critical business, educational, healthcare, and public safety needs, promoting “availability to all individuals, businesses, and institutions,... including those that require ultra-high-speed internet access”

- ⌘ Bring support to the underserved, targeting broadband development in areas with the highest level of broad-based benefit

- *Encourage public-private partnerships to fund a complete buildout of existing infrastructure, leveraging initiatives of healthcare, schools and libraries, business, and the public safety broadband network.* Completing the buildout will:

- ⌘ Maximize Maine’s existing physical infrastructure to support, strengthen and integrate Maine’s logical infrastructure, including business, healthcare, education, and public safety initiatives and grow business and retain IT expertise in the state, attract business from out of state, and improve Maine’s national ranking in the deployment of broadband telecommunications

- ⌘ Promote service provider competition, invigorating the drive to innovate, to invest in higher-capacity technologies, and to provide service that creates more consumer value for the dollar

- *Provide educational outreach on broadband’s value proposition (the benefits for the cost), targeted to specific audiences within each stakeholder group, including older citizens and small businesses.* A key driver of broadband internet subscribership, education on broadband’s benefits and opportunities will:

- ⌘ Encourage non-adopters to obtain a computer and to connect to the internet, closing the computer/internet gap and increasing the number of subscribers in the state

- ⌘ Encourage adopters to seek the advantages of higher-speed broadband, including distance-learning opportunities, telemedicine, and business out of state, advancing the knowledge, health and welfare of Maine’s citizens

- ⌘ Increase broadband uptake in the state, improving Maine’s ranking Nationally

- *Embrace mobile technology as broadband and leverage its power as a demand generator to drive broadband adoption.* Recognizing 4G mobile technology as broadband will:

- ⌘ Support the use of mobile devices as an introductory learning tool for computer and internet non- and late-adopters, helping to offset the challenge of Maine’s demographics

- ⌘ Increase availability of high-speed broadband service, particularly in remote areas with challenging terrain, helping to solve the problem of last-mile access
- ⌘ Increase broadband uptake in the state, improving Maine's ranking Nationally
- ⌘ Increase broadband funding through additional monthly surcharges on mobile services
- ⌘ Encourage mobile providers to innovate, including advancing transmission speeds and capacity.

Applications developed and initiated by HICKRC participating members, systems and providers include: transmission of various image files, PACS consolidation, remote radiology reads, specialty consultations; pharmacy applications (e-prescribing); administrative (billing & coding); clinical data (EHR transmission, patient portals); clinical and non-clinical distance learning; additional miscellaneous IT functions (remote servers, data back-up and storage, etc.). By supporting the State's broadband authority help meet its goals and objectives, while simultaneously improving access and services to health care providers, the Consortium helps Maine build momentum for high speed broadband services that meet the needs of today and shape the services of tomorrow.

D. Any previous experience in developing and managing health information technology

The State of Maine is recognized as a leader in Health Information Technology (HIT). As early as 1996, the State established the first All Payer Claims Database (APCD) in the nation with every health care payer in the State submitting all medical claims which are housed in a database for analysis and quality improvement. In 2006, Maine established the first State-wide Health Information Exchange (HIE) where every hospital and many health care practices submit clinical data on a real time basis. These data are accessible by health care providers to better treat patients and integrate healthcare. Current projects include linking the claims and clinical data to improve health outcomes and efficiencies for cost of care. The Department of Health and Human Services, Office of MaineCare Services, Meaningful Use Program, as the leader of the consortium has been a key factor in Health IT initiatives.

In 2006, Maine established the ConnectME Authority, an independent State agency governed by a public-private Board, to expand broadband capacity and use, particularly in unserved or under-served areas. Each year the Authority awards grants for projects that expand capacity to increase economic development, tele-health services, educational opportunities and improved health care. To date the Authority has awarded more than \$9 million dollars for projects totaling in excess \$17 million. The Authority administers a federal grant for mapping, planning, capacity building, and technical assistance.

The improvement of health information technology is framed by the HITECH Act which supports a federal/state partnership to continue to build HIT across the country. To that end, Maine has aligned its strategic HIT vision and goals with those of the Office of the National Coordinator, the federal Center for Medicaid and Medicare Services (CMS), and State decision makers to provide a system of person-centered, integrated, efficient, and evidence-based health care delivery for all Maine citizens. In 2010, as part of the federal HITECH Act, the Maine Department of Health and Human Services entered into a four-year cooperative agreement with the Office of the National Coordinator for HIT (ONC) through the establishment of Maine's Office of the State Coordinator for HIT (OSC.) The cooperative agreement resulted in a State-wide HIT Plan which guides the coordination of HIT technology and programs for the State of Maine. The HIT OSC is housed within the Department of Health and Human Services with oversight over all Health IT initiatives at the technical and program levels.

Since May 2011, the Maine Department of Health and Human Services has provided direct Health IT services through its Meaningful Use Program for health care providers. The State's program "go-live" began in October 2011 after successfully passing CMS Health IT testing and program protocol. In November 2012, Maine was recognized as the No. 1 state in the nation for the percentages of Eligible Professionals (EPs) who received payments for Adoption, Implementation or Update (AIU) and the first state in the nation to have all of its Eligible Hospitals (EHs) participate in the AIU Year 1 of the Medicaid incentive payment program. Maine is currently No. 1 in the nation for the highest percentage of Eligible Hospitals and Eligible Professionals who have successfully met Meaningful Use Stage 1 requirements. To date, the Meaningful Use Program has made over 3,800 payments totaling \$91 million, to Maine healthcare providers.

To be approved by CMS, the Department was required to conduct an extensive planning process that identified the state of the Department's Health IT "as-is" "to-be" "gap analysis" and culminated in a "roadmap for the future." Links to the State Medicaid Health Plan, Implementation Plan, and Meaningful Use program can be found at:

<http://www.maine.gov/dhhs/oms/HIT/index.html>

Maine will be submitting an update in late summer to its implementation plan to meet Stage 2 requirements for the Meaningful Use Program. The State of Maine will continue to build upon a solution that employs interaction and interoperability to maximize value and minimize burden and costs on providers, MaineCare members, and other stakeholders. For example, the update of the IAPD-U will request funds for the development and implementation of direct interfaces from providers to the State's CDC specialty registries, such as immunization, cancer, syndromic surveillance, diabetes, etc. This will provide an avenue to increase participation in the State's HIE by allowing providers to submit this data electronically through the HIE to the State's CDC and at the same time, demonstrates the value of the HIE and the exchange of clinical data. Maine expects to further the use of the State's HIE through appropriate linking of Medicaid EHR payments with participation in the HIE and with Maine's emerging value-based initiatives as well as working with community groups and patients to develop solutions that allow patients access to their health care data, quality and cost information.

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The Department uses a collaborative public-private stakeholder process to provide input and establish priorities and to identify and coordinate initiatives that have HIT components. The Department is a CMS State Innovation Model (SIM) grant state, a grant awarded to a select few states to test innovative service delivery and payment models. The Department's MaineCare Services has an approved Health Homes program which provides enhanced payments for health care providers who manage the care of patients with two or more chronic conditions. The Department is also undertaking an Accountable Care initiative to provide higher quality services as efficiently as possible. The Department has established a steering committee comprised of public and private decision makers including the HICKRC's Primary Project Coordinator, the Maine Health Data Organizations All Payer/All Claims database, HealthInfoNet, DHHS Offices, Maine Health Management Coalition Foundation, Maine Quality Counts, and other health care organizations and consumers.

The Primary Project Coordinator for the HICKRC is the State's OSC and the Director of the Department's MaineCare Meaningful Use Program. The Coordinator has been the Director of the MaineCare Meaningful Use Program since its inception and was responsible for the development of the State's Health IT and Program Medicaid Health Plan and implementation of the Meaningful Use Program. The Coordinator is a member of one of the three steering committee groups for the SIM grant; a director on the Board of Directors for HealthInfoNet, the State-wide HIE; a member of the APCD's stakeholder committee; and responsible for drafting the technical and program survey questions as well as the agreement manager for the memorandum of understanding with the ConnectME Authority and its contract for the baseline survey and report. The Coordinator is also the attorney who chairs the Legal Work Group that is responsible for reviewing, reporting, and making recommendations to decision makers on federal and State health IT privacy and security laws.

E. Project Management Plan

1. Consortium's Leadership and Management Structure:

The Health Information Connectivity-Knowledge Rural Consortium Project Management Plan's lead entity is the Meaningful Use Program within the Office of MaineCare Services, in the Maine Department of Health and Human Services. Dawn R. Gallagher is the Director of State Health Information Technology and Meaningful Use Program and is the Healthcare Connect Fund Primary Project Coordinator. Project management support services comprised of Consortium members' personnel support the HCF Project and report through the Members to the Primary Project Coordinator.

The HCF Project Plan includes a competitive bidding process from Electronic Telecommunication Carriers (ETC) already established (or with the ability to be established and provide or build out) broadband services throughout Maine to HICKRC Members. The HICKRC Leadership Management and Consortium Members are represented in Table 1. The membership is currently in its first year of existence.

Name	Title	Organization	City, State
Dawn R. Gallagher	Director State HIT and	Maine, DHHS, Office of	Augusta, ME

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	Meaningful Use Program HCF Primary Project Coordinator	MaineCare Services Consortium Lead	
Julie Shackley	CEO and President	Androscoggin Home Care & Hospice	Lewiston, ME
James Bouchard	Director of Marketing and Development	Androscoggin Home Care & Hospice	Lewiston, ME
Laurie Charbonneau	Administrator	Arnold Memorial Medical Center, PA	Jamesport, ME
Jan Hoskins	Director of Finance	Community Dental	Falmouth, ME
Lynn Duby*	CEO	Crisis & Counseling Centers	Augusta, ME
Michael Payne	CFO	DID Russell Medical Centers	Leeds, ME
Heather Pelletier	Executive Director	Fish River Rural Health	Eagle Lake, ME
Jane Dubois	Finance Officer	Fish River Rural Health	Eagle Lake, ME
Lee Humphrey	CEO	Harrington Family Health Center	Harrington, ME
Sue Dalton	Office Manager	Harrington Family Health Center	Harrington, ME
Claudette Humphrey	Director of Development/Grants Management	Katahdin Valley Health Centers	Patten, ME
Reynolds Raymond	CEO	Northern Maine General	Eagle Lake, ME
Missy Boutte	Accounting Supervisor	Northern Maine General	Eagle Lake, ME
Kim Gonzales	CFO	Penobscot Community Health Center	Bangor, ME
Ann Tucker	Chief Practice and Financial Officer	Portland Community Health Centers	Portland, ME
Charlene O 'Clair	Director of Finance	Sandcastle Clinical and Educational Services	Lewiston, ME
Dean Bailey*	Manager of Special Projects	Sweeter	Saco, ME
Terrence McCarthy	Director of Information Technology	York County Community Action Programs, Inc. (d.b.a. Masson Health Care)	Sanford, ME

* The organization is providing Administrative and Support Resources for the HICKRC.

2. Work Plan:

The Consortium Members and Lead Coordinator built upon the already existing HIT framework in Maine to organize the HICKRC. Many of the Consortium Members are stakeholders in the HIT Steering Committee and were early “ambassadors” for the HICKRC, and engaged interested HCP sites to join the newly developed HICKRC. The project management plan was developed with phased timelines, key milestone dates, a communication plan, and a risk identification and mitigation plan which can be viewed at: <http://www.maine.gov/hit/> under the Tele-health and Broadband folder. The project management plan serves as the work plan used for the status updates on progress, next steps, etc. with HCP Members and sites biweekly.

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3. Budget:

Participating healthcare provider sites will be responsible for paying 35% of the monthly fees directly under contracts they sign with ETC(s). Each HICKRC member has committed to paying the 35% requirement from their own business funds. Many Members have internet service and will actually achieve savings over their current rates that in turn, may enable them to obtain higher levels of service than what they have now. The Healthcare Connect Fund will pay 65% of the monthly fees for eligible sites, if a Funding Commitment Letter is obtained after a successful competitive bidding process and Funding Request is submitted to USAC. A Legal and Financial Agreement is already in place with all eligible Members. Non-eligible HCP sites will pay fair share rate, which is anticipated to be less than street rate value due to bulk-buying capacity and from being a HICKRC Member. Ineligible Costs are defined in paragraphs 164 through 177 of the Final Order. Specific examples included in the Order as ineligible costs include “Equipment or Services Not Directly Associated with Broadband Services”, “Inside Wiring/ Internal Connections”, and “Administrative Expenses.” The ineligible services can be bid on, yet must be paid in full by the healthcare providers.

Now that the initial formation of the HICKRC and the submission of draft network and RFP have been completed, future administrative costs of the HCF are being absorbed by the individual Members, in part, by a portion of the up to 65% “savings” in internet charges.

There are no membership fees for the HICKRC members which is a defining point for future growth of the HICKRC.

4. Schedule:

The HICKRC Project Management Plan’s schedule and timeline for the HICKRC HCF Project will be based on the timeframes relative to the Form 461 posting and time requirements (i. e. the RFP must be posted for 28 days). The HICKRC will then proceed in obtaining USAC commitment, reviewing and awarding contract(s) which is expected to take place by late summer. The HICKRC will the move to the implementation phase which will be based on site-specific needs.

Vendors that enter the competitive bidding process must include in their submitted proposals a detailed, Project Management Plan for implementing the private broadband Intranet and the public Internet Services for *all* HICKRC Members listed as Participating Entities on RFP **Attachment 1-2.**

Per the *Agreement Allocating Legal and Financial Responsibility Healthcare Connect Fund* all Participating Entities agreed to provide a representative from their organization to participate in the evaluation of vendor RFP responses during the competitive bidding process which will include a review of the detailed Project Management Plans received from competing Vendors.

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The contracts will be executed with individual HCPs, who determine whether signing a legal contract with the winning vendor for telecommunication services, is deemed advantageous to the HCP. This review includes Vendors' proposed Project Management Schedule and Timetable of when broadband services offered, and delivered.

The Project Management and Timelines criteria are defined in RFP, **Attachment 1-3** under Phases I-III. The mandatory detailed Project Management Plan shall include narrative information and detailed project milestone, target dates and completions dates and schedule information presented in Microsoft Project file format. The Vendor shall include an estimated start time and completion date for the entire project.

Vendors shall outline their implementation plan for the project described in the RFP. The plan shall include timetables that address the following issues:

Project Management: Provide a description of the Vendors' management team for this project. List all key personnel and their qualifications.

Project Schedule: Provide an implementation schedule for the proposed service, including delivery dates, implementation milestones, task relationships and dependencies, and a timeline.

Broadband System (private Intranet) and public Internet Services System Architecture and Development: Provide descriptions of how the service(s) will be designed, including details of customer testing and final implementation, the extent to which broadband (private Intranet) and public Internet connectivity to participating HICKRC entities will be guaranteed; how the private Intranet and public Internet service will deliver differentiated levels of service depending on the different bandwidth needs; quality of service (QoS) requirements of the HICKRC users.

HICKRC Project Management Plan to track vendor progress:

ID #	Task Name	Timeframe	Resource Name
191	12.1.1.2 Vendor installed/started requested services, network equip, etc.	Months 1-3	Vendor
192	12.1.1.2.1 HICKRC Network construction tracking – starts with contract sign date	Months 1-3	Dawn Gallagher (DG)
193	12.1.1.2.2 HCP site primary contact list for clinical and IT issues / questions	Month 1	DG
194	12.1.1.2.3 Roll out of services to HICKRC HCP per vendor timetable	Months 1-3	DG
195	12.1.1.2.4 Confirm testing of HICKRC Network is occurring by Vendor(s)	Months 1-3	DG
196	12.1.1.2.5 Evaluation and Progress services to HCPs	Months 2-3	DG

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HICKRC Project Management Plan's mitigation strategy in the event that no bids or no acceptable bids are received per the HICKRC RFP 01 and its evaluation criteria during the minimum 28 day posting period (ACSD) on the USAC website is to request from USAC that HICKRC HCP's remain with their current Vendors and to file F462 according USAC Forms filing guidelines.